

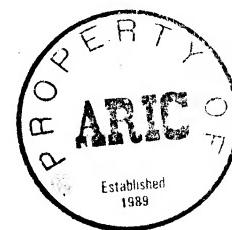
Working with people in the aftermath of crisis

Annual Report 1997



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HEALTH NET
INTERNATIONAL

Annual Report 1997



Foreword

In 1997, HealthNet International continued to prove just how important a role it is playing, albeit on a still modest scale. It is a role, clearly illustrated within this report, which provides the essential expertise to countries in the difficult period after war and before peace.

In these immediate post-conflict situations, the need for an organisation such as HealthNet to take over the emergency work and responsibilities of Médecins Sans Frontières is paramount. As such, the strength of our relationship with MSF Holland is the key to the success both of individual projects and of the organisations themselves.

Now that this relationship is firmly established and proven to be successful, we can begin to investigate how we can use our specific expertise and experience to work with other NGOs in a similar field.

Our donors, too, have become increasingly aware of the importance of HealthNet's work and their continued support, for which we are so grateful, has enabled us to develop this vital post-war specialism.

Particular thanks must go to our staff in the field and at the Amsterdam office. Their continuous support and sheer hard work are what make HealthNet the successful agency it is today and lays the foundations for developing that success in future years. As the Board, we are inspired time and again by the enthusiasm shown by all those involved in HealthNet.

Our belief is that those we exist to serve will be equally driven to ensure that the hard work done at this stage will benefit the communities for years to come.

On behalf of the Board



Peter K. H. Meyer Swantee
Chairman

1997

A Review

1997 marked HealthNet International's fifth anniversary. The original aim behind the foundation of HealthNet - that of bridging the gap between emergency and development - has proved to be addressing a real need in the humanitarian continuum. Much has been achieved in the past year, particularly the further reinforcement of our operational capacity and credibility in post-conflict development.

We have continued to learn a great deal from our programmes and partners and it is clear that we need now to focus our energies on strengthening our identity, mandate and future direction. We are entering a new phase in our life cycle, developing from adolescence to maturity, with confidence and strength.

¹ These are: Afghanistan, Cambodia, Djibouti, Ethiopia, Georgia, Mozambique, Pakistan, Peru, Romania, Rwanda, South-Sudan & Uganda.

² In Angola and Bosnia.

Programmes

Operationally, 1997 has confirmed the growing trend that HealthNet has experienced in previous years. We had 16 operational programmes in 12 countries¹, and two further programmes² at development stage. Together, they represent an input of 39 expatriates - of 16 different nationalities - in the field and over 200 national staff.

Donors have increased their support, a sign of the growing confidence in the quality of the proposals and work of HealthNet International. Early 1998 saw HealthNet's first ever contract with the European Community Humanitarian Office (ECHO). Although primarily an emergency-oriented organisation, ECHO's co-operation with HealthNet illustrates a new trend in the humanitarian world, where the emergency/rehabilitation/development cycle is increasingly viewed as a single process with no clear-cut borders in between.

In line with our overall purpose of bridging the gap between emergency and development, several programmes have been concluded successfully and/or handed over. In Uganda, for example, HealthNet has handed over its programme to a local NGO which it helped to establish. In Djibouti, HealthNet's primary health care programme was successfully integrated within the local Ministry of Health while in Ethiopia, the pilot phase of the Afar Pastoral Development Programme was completed and will be evaluated during 1998.

These hand-overs are a real indication of HealthNet's success, showing as they do that HealthNet has provided the necessary institutional support and technical assistance to enable its partners to continue on their own. HealthNet's aim at the onset of every programme is to prepare the conditions for its departure, usually by handing over to local non-governmental or institutional structures. Only in the case of Haiti, where our efforts to set up a district-level health department were abandoned due to lack of donor support, have we fallen short of our programme goal.

Consultancies

At HealthNet's current stage of development, it is difficult to undertake effective consultancy work without affecting programme quality. As a result, the amount of consultancy work undertaken on behalf of third parties was kept to a minimum and the totals reported in the Annual Financial Statements are almost exclusively project formulation missions. Given that there is certainly a need for consultancy work in the field of Public Health in post-conflict situations, HealthNet will focus on strengthening this capacity and developing expertise in the near future.

Internal organisation

In September, HealthNet held its 3rd Conference, gathering

together field Programme Managers, the office staff and Board members. This proved a valuable opportunity to gain input from the field staff on future strategy and in defining some priorities for the organisation. In this respect, most participants re-affirmed that HealthNet should continue to "specialise" in taking over former emergency programmes and providing the necessary support for the progression towards more sustainable development activities.

Within this strategy, the relationship between Médecins Sans Frontières Holland (MSF-H) and HealthNet was reinforced. Both organisations benefit a great deal from the relationship, which needs now to be better formalised within a new Strategic Alliance. This will be a major project for 1998.

1997 saw HealthNet's Head Office in Amsterdam expand with three new members of staff, two of whom came to newly created positions. This growth has been proportional to the growth of projects and therefore has not resulted in an increase in our relative indirect costs. On the contrary, benefiting from the advantages of economies of scale, we have been successful in decreasing the indirect cost rate from 14% in 1996 to less than 13%.

After four years at the helm, Egbert Sondorp, HealthNet's Director, announced his retirement from the organisation in order to pursue other interests abroad. The task of recruiting a top quality replacement is a priority for the coming year.

HealthNet International's finances

In 1997, the growth of the organisation in terms of overall income and expenditure has continued. Income has grown by 12% to Fl. 8,2 million, and expenditure by 24% to Fl. 8,4 million. In spite of the negative balance between income and expenditure, HealthNet's accumulated unrestricted funds have risen to almost Fl. 300.000, thus giving some financial flexibility in dealing with often insufficient grants from institutional donors or covering the costs of exploratory/assessment missions.

In 1997, our principal donors remained MSF-Holland, the European Union and the Dutch Government. There has also been a significant contribution from Stichting VISIO, a private Dutch foundation, which has committed itself to co-financing our programme for the control of river blindness disease in South Sudan.

Prospects

The humanitarian world is a complex environment, offering ever-changing challenges to those trying to make a difference. HealthNet International faces not only the internal demands of a young, developing organisation but also the external pressures of a more demanding environment. It is essential that all our partners and beneficiaries are actively involved in each phase of our programmes, from conception to

implementation and evaluation, a requirement which demands expert skills and experience from our field staff. Donor requirements are also more exacting, particularly regarding the contents of the programmes themselves and the exit strategies. Finally, our general working environment not only asks for more and more professionalism, expertise, quality and clear added-value in operations but also is increasingly competitive, especially in the area of human resources.

HealthNet International looks forward to these challenges and opportunities. Its still youthful enthusiasm and its technical capacity are its most valuable assets. Certainly, developing from adolescence to adulthood is no easy process and may even at times be painful. However, with the high level of commitment of everyone within the organisation, we are confident that we can continue to make a valuable and lasting contribution to the international effort to address the basic human right: access to quality health care for all.

Amsterdam, May 1998

The Management Committee,
Vincent Faber, Senior Programme Manager / Director a.i.
Jackie Lemlin, Senior Programme Manager
Jeroen Mous, Financial Manager

Projects in development

ANGOLA

Following independence in 1975, Angola experienced almost continual civil war until 1991. Elections in 1992 led to an escalation of the conflict and the destruction of most provincial capitals and rural infrastructures. A peace agreement in November 1994 brought the first signs of a possible end to the fighting and the formation, two and a half years later, of the Government of Unity and National Reconciliation marked a turning point in the Angola peace process.

With the opposition party, UNITA, now sending members of parliament to Luanda, both donors and development agencies are daring to believe that peace is becoming a reality. As a result, serious discussions have been taking place on moving away from emergency interventions to rehabilitation and development. It remains a delicate situation, with the international community watching to see whether the government and UNITA can resolve their continued political differences. Certainly, any donor investment in development will depend on the continued progress in the peace process and particularly on the resumption of state administration throughout the country and the presence of the UNITA in Luanda.

Outlook for 1997

Two assessments, carried out in 1996 and focusing on Malange Province, identified possible interventions, partners and donors. MSF, which was running emergency programmes in the Province, was preparing to hand over its activities if the peace process continued and assessments carried out by several donors recommended that development work should start with resources channelled through NGOs.

Following discussions with the Provincial Health Authorities, HealthNet identified several key objectives: to increase the capacity of municipal and provincial health authorities in setting health priorities, developing strategies and managing and implementing health services; to improve the health information system; to improve the delivery of integrated health services, particularly to the most vulnerable groups.

During 1998, HealthNet's efforts will be focused on establishing operational bases in Luanda and Malange Province, developing a concrete plan of action with Provincial level partners and preparing a long-term proposal for submission to interested donors.

End of year status

In August 1997, HealthNet began what has proved to be a slow process of establishing a base in Luanda. The Angolan

government is ambivalent to the idea of NGOs coming into the country and consequently has no clear rules concerning visas, work permits or registering individual organisations. A great deal of time, therefore, has had to be spent sorting out the legal requirements. In addition, the peace process itself has suffered setbacks and, while humanitarian operations continue, donors are wary of providing development funds. UNITA forces continue to occupy the countryside, posing a serious threat to the free movement of goods, services and people. Newly rehabilitated facilities are looted and destroyed and villages randomly attacked and their inhabitants displaced. It is now an accepted fact that UNITA forces number over 20,000 soldiers.

In Malange Province itself, there is renewed insecurity with troop movements by both sides increasing to the extent that even emergency operations have been suspended.

HealthNet will continue to monitor the situation in Angola in the hope that the tide will eventually turn and the possibility of helping to rebuild the health system becomes a reality.

HAÏTI

The poorest country in the Western hemisphere, Haiti's long-standing socio-economic problems were exacerbated in September 1991 with the military overthrow of the democratically-elected president, Jean-Bertrand Aristide. The

country was thrown into a state of emergency as fears mounted that the situation would deteriorate further into a full-scale civil war. Preparing for the worst, MSF set up a base on the island of La Gonave and began a range of projects focused primarily on delivering goods and services.

The already precarious state of millions of Haitians was further threatened when the international community imposed a trade embargo. Since then, the health of the population deteriorated sharply as they faced widespread poverty and environmental degradation.

In October 1995, following a request from MSF, HealthNet conducted an exploratory mission to La Gonave to assess the possibility of taking over the MSF programmes. In March 1996, HealthNet signed an agreement with MSF to assist in winding down their activities and explore the possibilities for longer-term programmes.

Outlook for 1997

During 1997, HealthNet reviewed the private health sector on La Gonave and began major discussions with donors to securing funding for a long-term project on the island. The project aimed both to improve health services through establishing a decentralised District Health Department and to reduce the transmission of HIV through the treatment of sexually-transmitted diseases, staff training, drugs supply and

general public health education. At the same time, HealthNet continued to support health education activities carried out primarily within schools.

External funding, however, proved elusive and HealthNet wound down its activities in Haiti before leaving at the end of 1997. In the end, La Gonave simply was not on donors' agendas, mainly because of its isolation and the lack of commitment from the Ministry of Health but also due to the extensive presence of missionary groups already providing some services.



Afghanistan

A new health structure in a

Nineteen years of civil war have left Afghanistan in ruins: its infrastructure and economy destroyed, its social and health services collapsed. Many have fled the country or sought refuge in camps.

1997 saw the Taliban maintain their control over most of the country save for the last strongholds of the opposition in the North where fighting continued. While Taliban rule has brought with it some stability, it has also brought a rigid interpretation of Islamic law. Women, particularly those in the more liberated cities, have found their freedom seriously curtailed. Today, the world waits to see whether the Taliban will be able to make the transition from an essentially religious movement into a civil administration capable of laying the foundations for lasting peace.

Location

Nangarhar Province, Eastern Region

Start date

September 1995

Target population

Autochton population and returnees from Pakistan

Partners

Ministry of Public Health, United Nations agencies

Financed by

MSF, EU/DG1, German Agro Action,
UNHCR, WFP and UNDCP

Expenditure 1997

Fl. 1,358,750

AFGHANISTAN

feudal society

One in four children here dies before the age of five, predominantly from preventable diseases. The years of war have left the health service in tatters. In those areas with at least some form of health care, the facilities are staffed by male health workers who are forbidden to see, touch and therefore treat female patients. For the Afghan women themselves, this lack of any adequate health care combined with a high fertility rate and poverty has made pregnancy and childbirth a dangerous and often fatal process. The Ministry of Public Health, as yet unable to resume its regular responsibilities, is being supported by WHO, UNICEF and a number of NGOs.

Health Care Support

Working with the Ministry of Public Health, HealthNet has introduced a new, decentralised management approach, which is less likely to be affected by political fluctuations at a higher level. The new system has been set up in a cluster of seven districts where the public health services were either non-existent or very poor and within the Hesar Shahi and New Hada camps. A rural hospital and three basic health centres have been established alongside two sub-health centres serving the most remote areas.

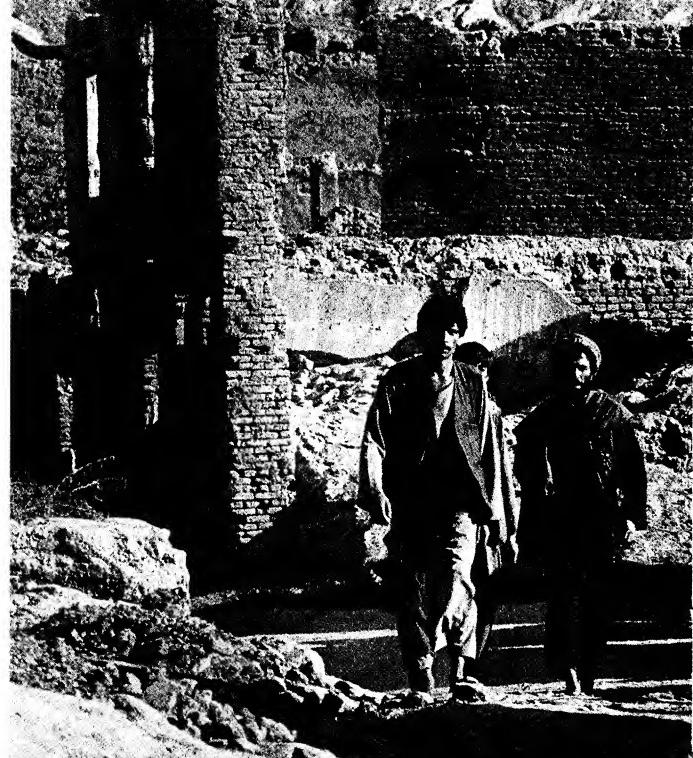
At the community level, HealthNet has trained 83 male Village Health Attendants and 45 female Traditional Birth Attendants to work within their own villages. Two female expatriates

worked to further develop the Mother and Child Health Care provision by supporting the MCH unit at the Ministry in Jalalabad and ensuring sufficient numbers of trained female staff at all the health facilities. By the end of 1997, 170 staff were employed, 24 of whom were women. The project has won the approval not only of the Ministry itself, WHO and UNICEF but more importantly of the population concerned.

Working closely with WHO and UNICEF, HealthNet has improved the immunisation coverage and upgraded the rural hospital. An x-ray unit and a sub-cold chain room were established, the operating theatre and laboratory were upgraded and a minibus purchased to serve as an additional ambulance. A piece of land next to the hospital, donated by the community, has been developed for farming and is now providing food for the patients.

The cost sharing system, by which patients pay for certain in- and out-patient services, was extended to all the new facilities with the result that 40-50% of the cost of drugs is recovered. It is a system which is widely accepted by the local community and, as such, serves as the basis for the long-term sustainability of the project.

HealthNet expects to be involved in this project for about five years, after which it will be handed over to the local government and/or the community itself.



Words are our trust

Dr. Ahmad Saboor Bahrami

One of three medical supervisors in the Health Care Support Project in Nangarhar Province, Eastern Afghanistan, Dr. Ahmad Saboor Bahrami has worked for HealthNet since April 1997. Born in 1961, his life and work have been heavily affected by the conflict in his home country. One of his brothers and three cousins have died in the fighting, school friends have either died or migrated and he himself has experienced the violence and hatred of war.

Dr. Bahrami was working with the Afghan Interim Government when fighting between rival factions of the Mujaheddin in Kabul in 1992 forced thousands to flee to camps near Jalalabad. He was sent with an 'emergency mobile unit' to set up Basic Health Centres in the camps with a special responsibility for feeding centres. With the support of WHO, he also attended a six month training course in Cairo on community nutrition.

The Taliban captured Jalalabad in September 1996 and, with new faces now in senior positions in the Ministry, Dr. Bahrami decided it was time to move and joined HealthNet seven months later. According to Dr. Bahrami, the approach of 'working with the community' is especially important in the area the Health Care Support Project is covering. Most of the people there belong to one of two tribes, the Shinwar and the Momand, both of which traditionally make a clear distinction between the worlds of men and women. They are mostly uneducated, have their own rules and regulations and do not automatically accept messages or advice from outsiders.



powerful tool

So communication skills are vital. "Words are our most powerful tool," he says. "If the community knows nothing about health or about your programme, how can you possibly serve them? This is a tough community and if we can succeed in setting up a Primary Health Care structure here, then it can surely be done anywhere else in Afghanistan."

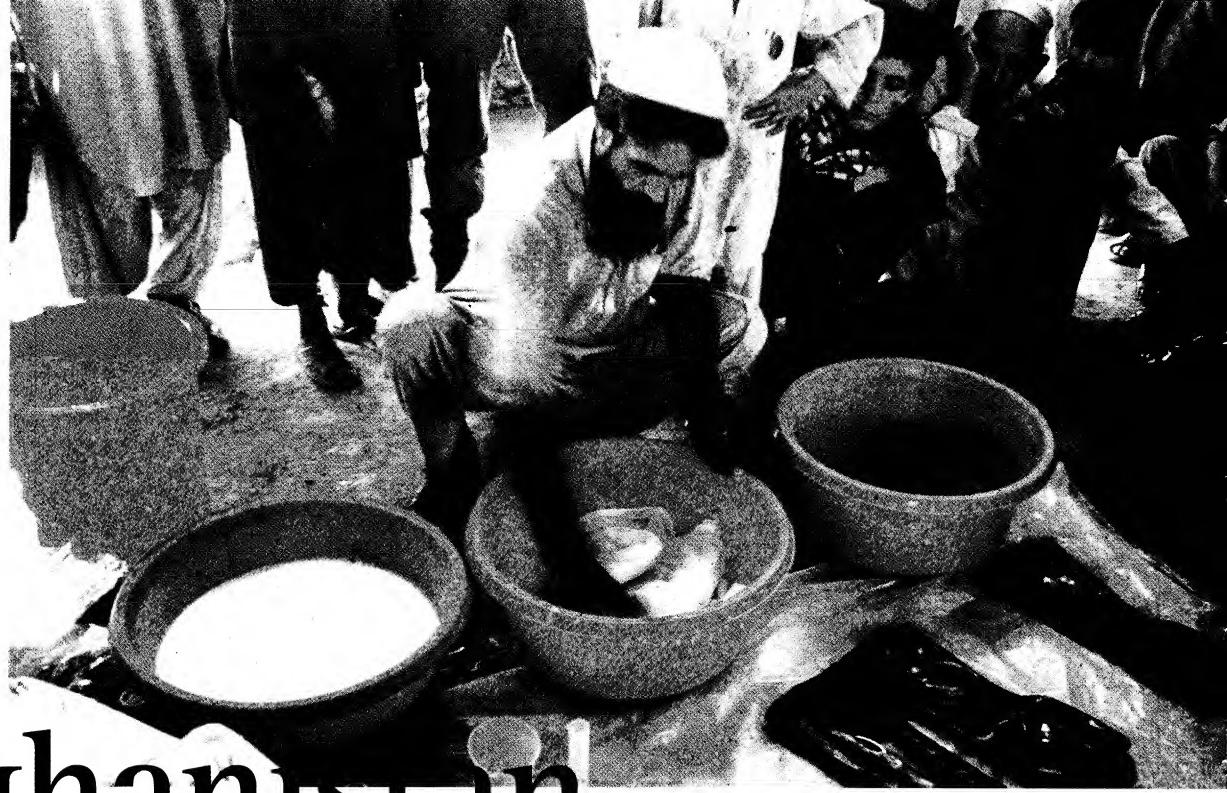
He is optimistic about the progress made to date. "HealthNet is well known in the area and the people have started to accept that both we and they have to make an effort if they want to see any improvement.

The village people provide the houses for medical staff, labour to improve the sanitation and are happy to pay a share of the services and drugs."

"We have a close relationship with the various community leaders and, by training traditional birth attendants and village health volunteers, our ideas are reaching more and more people."

Dr. Bahrami's work means that he is separated from his wife and four children. They live in Peshawar where there is access to education for the children while he spends the week sharing a room with three others.

He is philosophical about the future. "I hope for peace... meanwhile we are trying to rebuild our country. There was nothing left."



Afghanistan

Controlling a flybite of

Capital of Afghanistan, Kabul can lay claim to being the most war-damaged city in the world. With some 40% of its buildings in ruins, its assets looted and its people scattered, those who remain are subject to abject poverty in a community with little basic infrastructure. They cannot rely on food, fuel or shelter, sanitation and health services have largely broken down. Such services as do exist are provided mainly by NGOs.

Location

Kabul

Start date

December 1996

Target population

Local population in Kabul

Partners

Ministry of Public Health,
WHO,
UNHCR

Financed by

Norwegian Church Aid

Expenditure 1997

Fl. 137,559

AFGHANISTAN

epidemic proportions

With the front line for continued fighting just 25kms away and the restrictions on the access of women to health care, education and work, prospects for any kind of recovery in the city are not high.

These are conditions ripe for epidemics and the last four years have seen an explosive outbreak of cutaneous leishmaniasis (CL) which has left existing health services hopelessly overwhelmed. HealthNet surveys in 1997 showed that 30% of the poorest communities and 5% of the overall 1.2 million population of Kabul currently have active CL.

Transmitted by the simple bite of a sandfly, CL causes chronic ulceration which eventually heals to leave scarring and deformity, especially on the face. Treatment is expensive and time consuming and existing clinics have few resources. Monitoring and prevention strategies are non-existent.

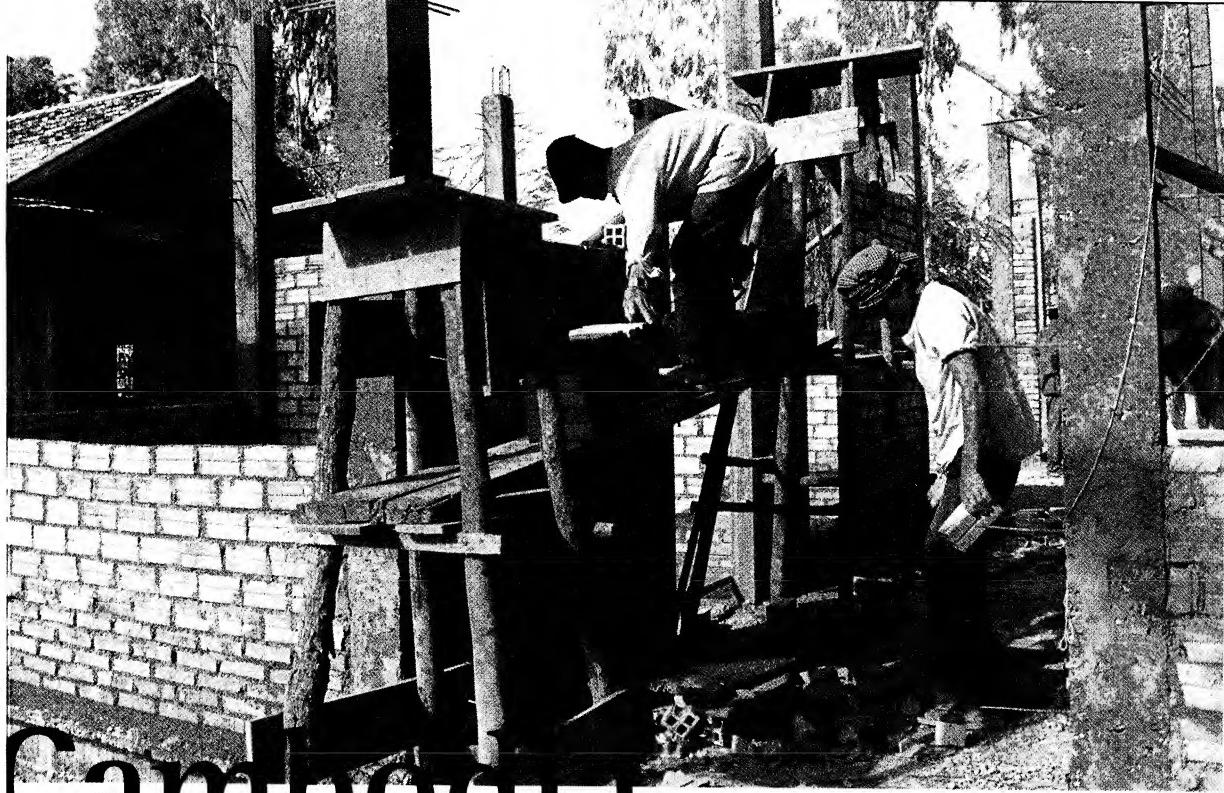
A CL treatment centre, set up in the most densely populated area of the city with drugs and other essential supplies provided by Pharmaciens Sans Frontières, has proved very successful. Some 500 new cases are treated per month, with priority given to the most severely affected patients.

Following an advisory visit by a joint HealthNet/WHO consultant in December 1997, a manual is now being prepared to establish standard guidelines for treatment.

In the immediate future, the plan is to expand all aspects of the project with funding from ECHO and the continued support and donation of bed-nets from WHO. Using the control strategies of bed-net sales and spraying with insecticide throughout the city over the next three years should achieve an initial 10-fold reduction in the incidence of CL. This will be linked to local capacity building with the Ministry of Public Health, the establishment of clinics and monitoring and prevention strategies.

Leishmaniasis Control Programme

Those areas worst affected by the CL outbreak were the prime targets for HealthNet's prevention programme in 1997. Here, too, the results were closely monitored. Male and female MoPH staff, trained and supervised by HealthNet, worked with the communities encouraging the use of bed-nets and spraying houses with insecticide. Both approaches have proved very popular with local communities and highly effective in preventing CL.



Cambodia

Step by step: together on the

Several decades of conflict have left Cambodia's physical infrastructure badly damaged and its people decimated. Following the elections of 1993, the country appeared to be working towards reconciliation, democracy and reconstruction with the formation of a coalition government of the former warring factions. It proved to be a fragile alliance which ended with a coup in 1997 and the ousting of the First Prime Minister. Although the political situation remains unstable, the Second Prime Minister, Hun Sen, does seem committed to taking the country peacefully through to democratic elections in July 1998.

Twenty years of inadequate diet, unclean water, bad sanitation and low quality medical care combined with the civil war means that the health of the majority of the population is very poor. In rural areas, which are heavily laden with landmines, less than 50% of the population has access to even the most basic health care. As a result, the health indicators make chilling reading. The infant mortality rate, for example, which stands as high as 900/100,000, is one of the highest in the world.

Common diseases such as malaria, tuberculosis (TB), diarrhoea and respiratory infection are widespread and severe while recent years have seen an escalation in sexually transmitted diseases, including AIDS. Given the inadequate health system, most people rely on self-medication or private and traditional practitioners.

Supporting public health services

Despite the difficult conditions, the MoH has done a commendable job in creating policy and planning the strengthening of integrated rural health services. The nationwide Health Coverage Plan, written in 1996, aims to provide an equitable and efficient distribution of effective basic health services.

Without sufficient resources to implement this system, however, the MoH turned to HealthNet and other NGOs for support with the construction or rehabilitation of health

Location
Svay Rieng Province, SE Cambodia

Start date
January 1994

Target population
Local population (470,000)

Partners
Provincial Health Department, UNICEF

Financed by
PACT/USAID, MSF Holland, UNICEF
German Embassy, Soforthilfe

Expenditure 1997
Fl. 469,930

Location
Banteay Meanchey Province,
NW Cambodia

Start date
October 1995

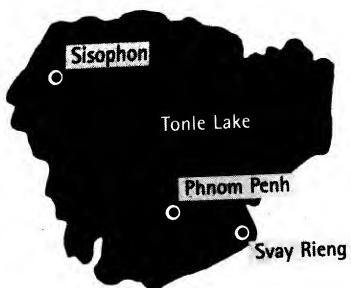
Target population
Local population (210,000)

Partners
Provincial Health Department,
other NGOs

Financed by
MSF

Expenditure 1997
Fl. 485,489

CAMBODIA



road to health

clinics, essential drugs distribution, intensive staff training at all levels and the provision of an acceptable level of basic health care services. HealthNet will also help the Provincial Health Authorities both to co-ordinate the relevant NGOs in the region and to ensure the consistency and quality of the training for government health staff.

HealthNet has been active in Banteay Meanchey province, in the NW of the country, since February 1996 when it took over the activities of MSF in four sub-districts. One of the most important activities since then has been a comprehensive participatory community baseline survey looking at health needs, attitudes and the quality of existing services. The resulting report is being used as the basis for all HealthNet's activities. In addition, HealthNet has built two health centres, supplied essential drugs and equipment and trained 35 local health staff.

In the coming year, HealthNet will be taking the lead role in the development both of the referral hospital and the district management structure for one district. In another, HealthNet will build and equip two new health centres, serving an estimated 28,000 people, and provide training for the staff. Clinical and management support to the two health centres built in 1997 will continue, as will support to the four TB clinics across the province.

Capacity building for quality health care

HealthNet's focus in the three operational districts of Svay Rieng province, in the SE of the country, is to improve access to quality health care through improving maternal and child health care, strengthening the planning and management capacities of each operational level (health centre/district/province) and improving community participation.

Working closely with UNICEF and the Provincial Health Department, HealthNet has been particularly successful in implementing the health reforms proposed by the MoH. As part of these, two new health centres were built during the year and the staff of eight such centres given practical and theoretical training. The supervision and referral systems between the health centres, the district and the province was improved and a standard training curriculum to ensure consistent skills across the province was finalised. The training itself will be provided by a specially-formed team of provincial and district health staff.

As a result of this work, five new health centres could become operational and two former district hospitals remodelled into health centres, thus increasing the access of at least 100,000 people to affordable and reliable health care.

Alongside the strengthening of the infrastructure, it was also important to improve the drug supply and health information systems. With HealthNet's support, health information is now



Djibouti

Getting it

bring used as a planning tool and far fewer drugs shortages occur.

Active community participation is essential to sustainability. HealthNet therefore established community committees alongside every new health centre and it was representatives of the target communities who decided on the level of fees to be charged.

The Mother and Child Health services continued to receive support with the result that ante-natal and family planning consultations increased. At the same time, HealthNet's MCH advisor trained over 80 Traditional Birth Attendants.

The overall aim, which continued during 1997, is to build the capacity of the local health staff to enable them to take over responsibility for the main programmes with HealthNet's involvement gradually becoming increasingly supervisory and facilitating.

One of the main activities in 1998 will be to support the training of staff in 12 new health centres and improve the management skills of district management teams.

The political instability throughout the Horn of Africa in the 1990s has had a serious impact on the health and well-being of people in countries across the region and Djibouti is no exception. This small country on the shores of the Red Sea has found itself host to refugees fleeing the civil conflicts in Somalia, Somaliland and Ethiopia as well as coping with its own people displaced by armed opposition groups in the northern part of the country.

Location

Balbala peri-urban area, Djibouti-Ville

Start date

September 1993

End date

August 1997

Target population

Refugees, internally displaced persons,
peri-urban population

Partner

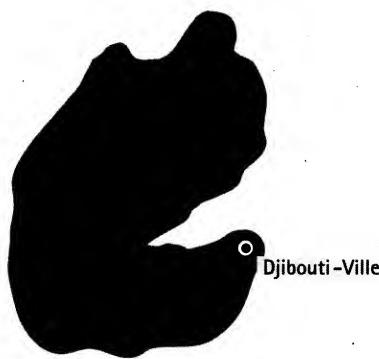
Ministry of Health

Financed by

European Union

Expenditure 1997

Fl. 156,027

DJIBOUTI

right at the grass roots

With most refugees and displaced people arriving in Djibouti town, a peri-urban area, Balbala, has developed. It is seriously over-crowded with no access to clean water, safe waste disposal, health care or proper housing. Any attempt to relocate the population to date has been unsuccessful and, with instability continuing in the region, it now appears that most people will stay permanently.

Such health care as does exist in Balbala simply has not kept up with the rapid increase in the population. Diarrhoea and acute respiratory diseases are rife and many of the children are seriously malnourished. At the same time, the government's implementation of a structural adjustment programme, recommended by the IMF and World Bank, has led to cuts in social spending which have been felt most acutely at the community level. So, while health facilities do exist, there are few well-motivated, trained staff, insufficient drugs and materials, little in the way of a reliable health information system and a real lack of understanding on the part of the community about preventive health.

Support to Primary Health Care

The priority in Balbala is to improve primary health care through providing technical support to all levels of staff and focusing on the integration of Mother and Child Health activities. Management and planning training, therefore, was organised for health staff, who were also supervised and supported in the provision of drugs and medical supplies.

One key activity has been to strengthen health care and information at community level by creating health committees and developing training courses for both trainers themselves, traditional birth attendants and community health workers. The community health workers, who operate through home visiting and organising regular health education meetings, are a vital link in the chain. They provide a service and improve health awareness at the heart of the community as well as being responsible for collecting essential epidemiological data. Expanding the network of health committees and community health workers, therefore, has been a top priority for the year. As a result, over 100 health workers were trained and health committees established in five areas of Balbala.

The success of this approach is clear from the improving number of 0-5 year consultations at the health centres and increased vaccination coverage, although both remain below the national targets.

In addition, the community health workers are now capable of dealing with the moderate to mild cases of malnutrition leaving only the most severe cases to be referred to the nutritional rehabilitation centres. These centres were established by HealthNet specifically to provide both supplementary feeding for malnourished children and essential nutritional education for mothers.

The programme was handed over successfully to HealthNet's main implementing partner, the Health Education Department of the Ministry of Health, in August.



Ethiopia

Development of health care

On 21 May 1991, the 17-year Mengistu regime collapsed and the Ethiopian Peoples Revolutionary Democratic Front (EPRDF) marched into Addis Ababa.

The transitional government then installed was replaced in 1995 by a democratically-elected government which set to work implementing a radical plan of action by which the country is divided into nine regional states primarily based on ethnic identity.

Each region has its own government and organises social services to meet the needs of its population. However, many have been long neglected and lack vital manpower, infrastructure and resources. One such region, Afar, is populated by semi-nomadic pastoralists who currently have little access to any form of modern health care.

There is little in the way of reliable health information on the Afar region but the indications are that the health of the population is poor with high rates of mortality and morbidity. The causes are similar to those which plague the rest of the country: diarrhoea, acute respiratory infection, malaria, tuberculosis and complications associated with pregnancy and labour. Despite malaria being considered one of the main culprits, rapid surveys carried out by HealthNet indicate a very low vaccination coverage.

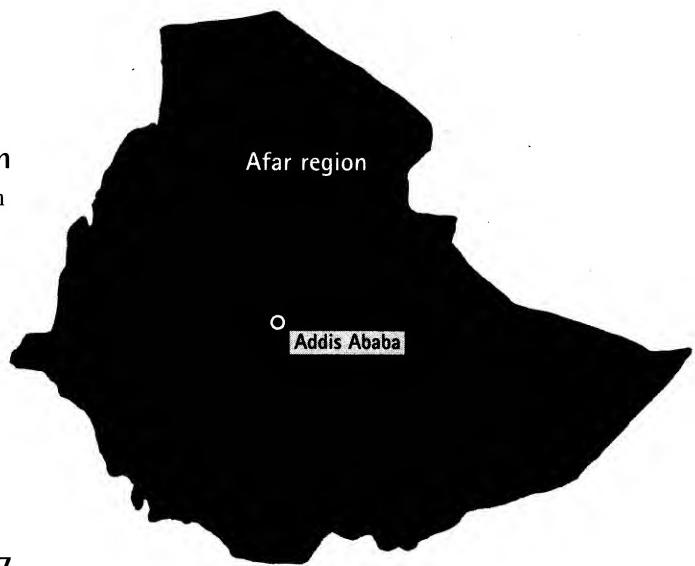
Current health services in the region are not meeting the needs of the Afar people. Their nomadic lifestyles, the high cost of drugs, their own cultural practices and beliefs and their language all represent barriers preventing the people from having ready access to essential health care.

Afar Pastoral Development

Focusing on improving health services through training and management support, HealthNet has identified two core requirements: strengthening the existing health system and developing a reliable network of trained, community-based health workers.

Location	Location
Afar Region	Addis-Ababa
Start date	Start date
June 1995	May 1997
End date	Target population
June 1997	Peri-urban population in Akaki-Kaliti area
Target population	Partners
70,000 nomadic pastoralists	Local NGO (Health Aid Ethiopia)
Partners	Financed by
Ministry of Health at regional and zone level	MSF Holland
Financed by	Expenditure 1997
European Union	Fl. 164,625
Expenditure 1997	Fl. 281,354

Location	ETHIOPIA
Addis-Ababa	
Start date	
May 1997	
Target population	
Peri-urban population in Akaki-Kaliti area	
Partners	
Local NGO (Health Aid Ethiopia)	
Financed by	
MSF Holland	
Expenditure 1997	
Fl. 164,625	



for a nomadic population

Addressing these, HealthNet worked in partnership with the Ethiopian Management Training Institute to provide management training to the Zonal Health Team. Working in partnership again, this time with the health authorities and UNICEF, HealthNet also organised a campaign to re-vitalise the vaccination service, training five teams of health professionals over a three week period. Each of the 45 health professionals also attended refresher courses every month throughout the year. The same approach was taken with the 60 community health workers. The 26 traditional birth attendants were re-trained to encourage more hygienic and safer childbirth.

Two new clinics were built, another four facilities renovated and clinical outreach activities supported. As a result, the access of the population to health services has improved dramatically. Staff have also given logistical management support during outbreaks of rabies, measles and malaria.

The pilot phase of this project ended in June 1997 with HealthNet handing over its activities to the local health authorities. The European Union will carry out an evaluation during 1998.

Building the capacity of local NGOs

With the current restructuring both of the Ethiopian Ministry of Health and the country as a whole, the health care services are suffering. In this situation, encouraging the full

participation of local experts and actively involving local communities in projects is vital to improve access to and the standard of available medical care. Recognising this, local NGOs have set up several programmes to meet the needs of the population. Their role is important, particularly in areas such as suburban Addis Ababa where poverty and unemployment go hand in hand.

Ethiopia's health care policy is to provide similar standards of primary health care to both urban and rural populations. However, most planning has worked from the top down and health units on the periphery are grossly under-budgeted. The people themselves have little faith in the health care provision and the services are under-utilised. As a result, morbidity and mortality rates in these areas are noticeably high.

Co-operation HealthNet-HAE/ICD

In Akaki-Kaliti, a local NGO, Health Aid Ethiopia/Integrated Community Development (HAE/ICD), has been working to improve the health of the population since 1995. After initial support from MSF, the project was handed over to HealthNet in May 1997. The primary objective has been to help HAE/ICD staff develop the management, planning and financial skills necessary to have an effective impact. Equally important, HealthNet has trained the staff in outreach activities, bringing the health services direct to the people, and involving the communities themselves.



Georgia

Ensuring

Working with the pharmacy staff, HealthNet has also established a revolving drug system, while outreach staff have been trained in the supervision and set up of a community-based primary health care system. Additional support was given during the 1997 National Polio Vaccination Campaign.

HealthNet provides financial support to HAE/ICD to pay local salaries, overhead costs, drugs and medical supplies and fuel and maintenance for their vehicle. By the end of the current project period, it is expected that HAE/ICD will have developed the financial, human resources and logistics systems to support key primary health care programmes which have the full support of the communities concerned.

Before declaring its independence in 1991, Georgia's economy was a well-integrated component of the Soviet machine. The collapse of the Soviet Union, therefore, threw Georgia into economic decline. The human and material damage caused by the ethnic violence and a civil war weakened the economy still further.

The subsequent internal displacement of 280,000 people added an extra burden to the already floundering political and economic systems. However, the election as president of the former USSR Foreign Minister, Eduard Shevardnadze, in 1995 signalled an era of stability that persists to this day. Georgia is now committed to economic and monetary reform.

Location

Achara, Guria and Poti Regions, South-West Georgia

Start date

December 1996

Target population

Internally displaced and vulnerable groups

Partner

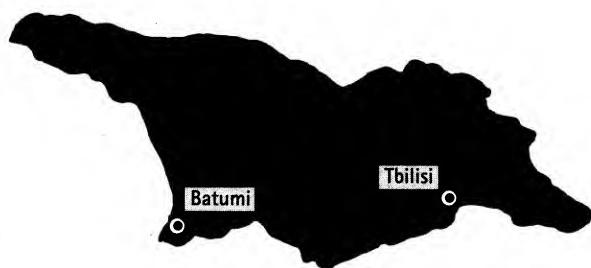
Regional Health Authorities

Financed by

MSF Holland

Expenditure 1997

Fl. 560,056

GEORGIA

health care for a country in transition

Reliable and accessible health care was one of the casualties of the weakened political and economic systems. With facilities and services deteriorating, the people lost confidence in the system and overall public health declined. Although reforms introduced in 1995 aimed to restructure the health system into one which was decentralised, responsive to need and made rational use of resources, budget shortfalls have meant that little government funding has reached the health facilities. Health directors lack management skills, facilities are overburdened with poorly-paid staff and the charging of illegal fees has thus been legitimised.

The situation is worst in those regions furthest from the capital. As a result, HealthNet has targeted its projects in the south west of the country.

Health Care Development

Building on the foundations laid by MSF, HealthNet has become promotor and facilitator of innovative processes in the health care reform process.

Staff continued the MSF Drug Distribution Programme (DDP) by which essential drugs and medical supplies are purchased on the international market and distributed bi-monthly to 51 health facilities. These drugs are only made available to pre-defined vulnerable groups. Sadly, attempts to develop the DDP into a non-profit Medical Store, a new concept in Georgia, proved unsuccessful and this aspect of the project was

discontinued at the end of the year.

HealthNet also took over the management and development of the Kobuleti Dispensary for Vulnerable People. This serves the most vulnerable 10% of the total population - pensioners without support, displaced people and poor families identified as such by a socio-economic screening system originally developed by MSF. The aim is to integrate the Dispensary into the State Health System, develop and promote the screening system and, ultimately, to provide a model for future development projects organised in similar emergency situations.

A further project taken over from MSF was the safe blood transfusion system through HIV and Hepatitis B testing. As the leading NGO working with the UN/AIDS Group, HealthNet focused on promoting increased understanding of the diseases and an awareness of risk behaviour. Staff conducted seminars given by Georgian consultants at health facilities in the target area.

Working together with UNICEF, HealthNet prepared an analytical overview of the Health Care Reforms and Financing in Georgia. The final report not only identified the practical achievements to date and those still planned but also detailed the objectives and guiding principles of the reform process itself.

With the reforms bringing with them additional tasks and



Mozambique

Putting the basics in

responsibilities for health facility directors, most of whom are physicians with little management training, the Georgian Ministry of Health asked HealthNet to develop a relevant training course. The proposal for this training will be developed in 1998.

Five years have passed since the end of the civil war and, with a multi-party system in existence since 1994, the last three years have seen a period of relative political stability. Yet, despite the improving political situation, Mozambique is still in the process of reconstruction and remains one of the poorest countries in the world.

Location
Nampula Province

Start date
July 1994

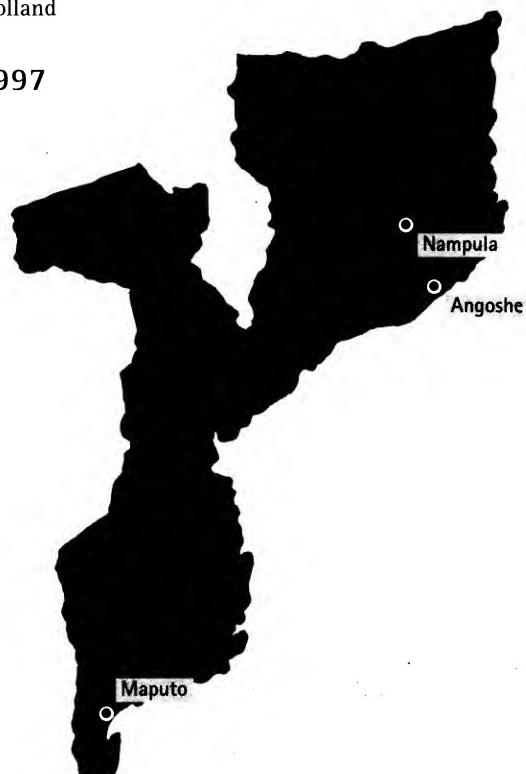
Target population
Local population in four districts,
estimated 800,000

Partners
District and Provincial
Health Authorities

Financed by
DGIS , ICCO, MSF-Holland

Expenditure 1997
Fl. 657,997

MOZAMBIQUE



place

Life expectancy in Mozambique is just 47 years, a figure which is in part the result of very high infant, child and maternal mortality rates. It is estimated that just 40% of the population has access to any formal health service. The health infrastructure which was destroyed or deteriorated during the civil war has yet to be completely restored. National health services lack the financial, material and human resources to maintain even the existing structures or provide a minimum basic health service to rural areas.

Health care support

In 1997, the end of the first phase of its support to the Angoche Region, training, community participation and the Health System Research initiative were the focus of HealthNet's work.

With technical and financial support provided to District Health Department trainers, established by HealthNet in 1996, all 95 traditional birth attendants (TBAs) and 46 village health workers had their current knowledge brought up to date and, in Angoche district itself, all 28 TBAs were given specific training in family planning.

In 1996, a Participatory Rural Appraisal identified the need for training in basic health concepts and health education approaches. During the year, this training was also provided for representatives of the community of Quilua Island.

Village health committees are vital if community participation is to be encouraged, a fact borne out by the results of a survey carried out in Nkopola to measure the impact of its committee. HealthNet therefore continued its support of these committees and provided up to date training for the members. One new committee was also established in Mieie town.

The second part of the course on Health Systems Research, by which district research teams learn to analyse results, report findings and develop subsequent plans of action, was held. The teams explored priority issues for their districts, including the causes of patient discontinuation of treatment for leprosy and tuberculosis, the social and economic impacts of Konzo Disease, and the knowledge, attitude and practices related to sexually transmitted diseases.

The ongoing support to the Provincial Health Department efforts to produce an integrated MCH vaccination supervision guide continued throughout the year and specific help was given during vaccination campaigns and similar activities.

Following HealthNet's review of its Angoche Region project in mid-1997, the decision was taken to continue working here for another three years, focusing specifically on MCH and reproductive health services, vaccination programmes, the rehabilitation of the health infrastructure, supply management and rational drug use.



Pakistan/Afghanistan

New weapons against an old

Up to 1.5 million Afghans, unwilling to return to a war-torn homeland without basic infrastructure or living conditions, still reside in refugee camps in Pakistan. While the strict rule of the Taliban has brought some stability to the South and East, civil war against the alliance of Mujehideen and former Soviet-supported militias continues to disrupt the North and frustrate the Taliban. Known and criticised internationally for their repressive policies towards women and imposition of extreme religious dogma, the Taliban views operations with NGOs and UN agencies with suspicion. Yet the refugees are unlikely to return unless the outlook improves.

According to the UN Human Development Index, Afghanistan is the poorest country in Asia and its health services are correspondingly woefully deficient. Diseases kill one in four children before their fifth birthday, with malaria particularly prevalent during the war due to the breakdown in the health system, disruption of control and the mass movement of refugees with no natural immunity. The improvement in security over the last few years, however, has led to increased provision of health care from UN and NGO agencies under the nominal control of the Taliban-led Ministry of Public Health.

Malaria control

HealthNet took over the malaria control project from MSF in 1993 and innovative techniques introduced since then have been considerably successful.

Sponging down livestock and domestic animals with deltamethrin insecticide, for example, has proved both dramatically more cost-efficient and more effective than the alternative standard technique of house spraying. This approach was expanded within the Pakistan refugee camps in 1997 and introduced into Afghanistan for the first time. The impact on falciparum malaria in the badly affected Adizai camp was to reduce the disease from 1,032 cases in 1996 to just 44 in 1997 - at a cost of just \$125.

Another technique which has proved particularly effective is

Location

North-West frontier and Balochistan Provinces

Start date

October 1993

Target population

Afghan refugees in Pakistan,
local population in Afghanistan

Partners

Ministry of Public Health, UNHCR, WHO,
local and international NGOs

Financed by

European Union, UNHCR, WHO

Expenditure 1997

Fl. 713,157

PAKISTAN/AFGHANISTAN

enemy

the supply of impregnated bed nets. Sales of over 200,000 bed nets in eastern Afghanistan since 1993 are protecting an estimated 700,000 inhabitants. However, the need to retreat the nets every year has presented a logistical problem and a variety of distribution methods have been tested, ranging from recruiting and training community volunteers to treat nets locally for a small commission, to packaging the insecticide into sachets and selling them through private sector clinics, pharmacies and shops. The sachets have proved the most popular method since many people live far from the towns and sachets can be taken home and stored until needed.

Private sector development is probably the most sustainable solution in a country such as Afghanistan which can never rely completely on public service provision.

For those unable to afford bednets, treating chaddors (Islamic head and body wraps) or outer bed sheets with permethrin insecticide has proved cheaper and only slightly less effective, giving up to 50% protection.

An integrated approach using all three techniques can ensure an entire community receives protection of one form or another. This has been pioneered in the Behsud district and will be expanded to Shinwar in 1998.

In Kunar, the withdrawal of donor support led to the closure of the province's only hospital. When an epidemic of falciparum malaria broke out in Watapur and Ningalam districts,

therefore, it was only overcome by a co-ordinated response from HealthNet and the MoPH involving the mass treatment of 2,500 fever patients with choloroquine.

HealthNet continued to provide a training service for partner NGOs with 18 courses run for malaria microscopists and doctors. This was particularly significant in north-eastern Afghanistan where unconfirmed reports suggest that falciparum malaria has become endemic. Microscopy will provide the proof.



Peru

Bringing mother and child health to

Since taking over the government of Peru, Fujimori has achieved two key things. Firstly, he has brought the civil war which had paralysed the country for 14 years to an end. Secondly, he has reduced inflation from over 2000% in 1990 to single figures in 1997. As a result, foreign investment, especially from Japan, has more than doubled and the government's own investment in health, education and social services has increased.

Despite this, however, unemployment and under-employment remains high, certainly over the official rate of 10%. Under-employment is a particular problem with engineers, accountants and lawyers, among others, working as taxi drivers or administrators simply to earn a living.

The health status in Ayacucho is poor with high rates infant and maternal mortality. Respiratory infections and diarrhoeal diseases are the main causes of infant deaths, while post partum infections, toxæmia and labour complications are responsible for the deaths of most of the mothers. Despite improved health coverage, over 75% of women continue to give birth without a trained person at hand. Only 16.7% of women who died in childbirth in the first half of 1997 were attended by a trained person, compared to 55.5% who died while attended by a relative.

Technical support to MSF-H programme of mother and child health

HealthNet took over the MCH programme in Ayacucho, providing mother and child health care to returnees and displaced people, from MSF in 1996 with two objectives. Firstly, to act as an advisory body and, secondly, to help the local MSF team to develop sufficiently to become an NGO in their own right and capable of taking over the programme itself.

Location
Ayacucho region

Start date
December 1996

Target population
Internally displaced and returnees,
Indian communities

Partners
MSF, Ministry of Health

Financed by
MSF

Expenditure 1997
Fl. 179,543

PERU



the communities

Field visits in 1997 and discussions with both local and expatriate MSF team members showed that the knowledge and skills of the local team needed to be strengthened if it was to be able to fulfil the future needs of the programme. Training was organised but a decision has been taken to monitor the development carefully before registering the team as an NGO. In the meantime, HealthNet will assess the viability of working directly with the community-based organisations.

Manager, will begin in 1998. Although community-based, HealthNet will continue to work with the Ministry of Health to ensure a better integration of formal and informal health care.

Mental health

In collaboration with MSF Ayacucho, HealthNet carried out a three month anthropological and mental health study of the area. The final report recommended that the present programme emphasis of a curative supportive role to MoH health establishments be shifted to that of a community-based health programme.

The study results suggested that the main area of weakness was in the community structure with the main problem being quality of service rather than lack of facilities and a lack of preventative rather than curative health care.

Consequently, a new two-year programme proposal for community health and social rehabilitation was put together and submitted to MSF for approval and funding. This was given in December 1997 and the project, which will involve working with 12 local staff and one expatriate Programme



Romania

Fellowships for Romanian medical

Since the revolution of 1989, Romania slowly moves towards democracy and economic reform. However, political instability and economic decline have left large sections of the population impoverished. The country's 40 years of isolation have left their mark: its civil society is not yet very developed and, to a large extent, the state is still managed by groups with vested interests. Due to a lack of effective family planning, the number of unwanted pregnancies is high and many children end up in institutions. Maternal and child mortality rates are the highest in Europe.

In common with other eastern European countries, the health system needs to be completely reformed if it is to become effective and efficient. Currently hospital-oriented with a large number of hospitals and beds, it needs to develop into a patient-oriented system which emphasises effective first line health care - home care and family practitioners.

Only 2.8% of GNP is allocated to the health system and even that is badly managed. With drugs in short supply and salaries extremely low, trained medical specialists are leaving the country for the west.

Many international organisations continue to support the health care system in Romania.

Some Dutch programmes are aimed at encouraging the necessary reforms. The Dutch system, which is heavily based on primary health care, serves as a useful example.

Support to Romanian medical specialists

Every year since 1990, some 15 Romanian medical specialists have taken a two month fellowship in a Dutch hospital so they can see for themselves the benefits of a modern health system and become agents of change in their own country. All clinical specialisations are eligible although, in reality, about a third are interns and there are many surgeons, paediatricians and ophthalmologists.

Once the annual selection of the specialists is complete, based

Location

Romania

Start date

The project was started in 1990 by MSF-Holland and taken over by HealthNet in 1996

Target population

Medical specialists from throughout Romania

although mainly from Transylvania

Indirectly: patients in hospitals in Romania

Partners

In Romania: Duromef, a local NGO

In the Netherlands: Dutch medical specialists who are prepared to receive a colleague from Romania

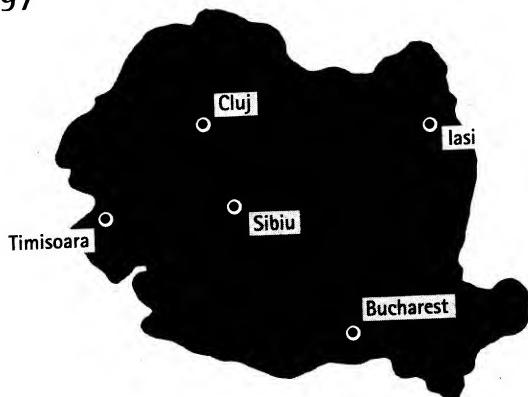
Financed by

MSF-Holland

ROMANIA

Expenditure 1997

Fl. 200,127



specialists

on certain criteria including professional interest, language skills and age (under 40 years), the search for a relevant Dutch specialist willing to devote a substantial amount of time on their Romanian colleague begins.

Nearly always, a match is found, with some Dutch specialists having participated several times. Most fellowships are based in the randstad, with the university hospitals of Utrecht and Amsterdam taking the largest number of specialists.

By the end of 1997, 121 Romanian specialists have completed such a fellowship since 1990. Although lack of equipment or organisation means that certain techniques will not transfer easily to Romania, there remains a huge range of relevant, up-to-date skills which will. The visiting specialists also have the chance to see how the Dutch system works and what can be taken back. For many, for example, the use of diagnostic or treatment protocols or guidelines is completely new.

In 1993, the Romanian specialists who had by then completed the fellowship founded an association, Duromef, by which they could keep in touch with each other and preserve the "Dutch experience". Today, supported by HealthNet, Duromef has 98 members and is actively involved in the annual selection of new candidates. Members have organised two workshops on hospital management, hold an annual meeting and publish a medical magazine. HealthNet also gives each member an annual subscription to a medical magazine.

Under HealthNet's supervision, the programme is planned and

managed by four Dutch medical specialists, a hospital manager and a Programm manager.



Rwanda

Not dead... but forgotten

1994's genocide in Rwanda claimed the lives of almost a million Tutsis and moderate Hutus. Over a million more fled the country. Rwanda was left empty and it was up to the Rwandan Patriotic Army, which had seized power, to construct a reconciled and stable country. A great deal has been achieved in the last two years and at first glance the country is functioning as any other in Africa. A closer look, however, shows that Rwanda still faces tremendous challenges in the aftermath of war, genocide and insecurity. The massive return of Rwandan refugees in 1996 went hand in hand with a serious increase in security incidents. Two years after the genocide, peace and reconciliation still seem a long way off.

The Rwandan health system suffered badly in the war. Its health facilities were looted or destroyed and its staff either killed or forced to flee. Many of those who survived the genocide were left disabled or mutilated either by direct attack or by the lack of proper medical care. According to a 1995 survey, there were 2,000 civilian amputees in Rwanda, most of whom had not received adequate treatment. Many more people were suffering the results of badly-healed fractures, nerve damage, paralysis and injuries to the spinal cord, all of whom need treatment and rehabilitation.

Although the number of qualified medical staff working in the country has risen since 1994, many are newly qualified and lack the practical experience necessary to meet the needs.

Rehabilitation care for Rwanda

HealthNet's primary aim in Rwanda is to support all efforts to provide appropriate physical and social rehabilitation facilities throughout the country.

At the beginning of the programme, HealthNet gave a great deal of support to the King Faisal Hospital, which had been heavily used during the war and was now developing a specialised rehabilitation centre. It was clear, however, that the number of patients being referred here not only exceeded capacity but many did not need the level of specialist care provided by the hospital and, in an ideal world, should be treated at district level.

Location

National level, 11 health districts

RWANDA**Start date**

August 1995

Target population

Disabled and vulnerable groups

Partners

Ministry of Health

Local and international NGOs

Financed by

MSF Holland

European Union

Expenditure 1997

Fl. 484,183

With medical staff at district level inexperienced and lacking essential equipment and materials, specific training was necessary. Working with the Ministry of Health, HealthNet developed a training programme for district physicians and nursing staff in eleven districts focusing on the most common orthopaedic problems.

During 1997, HealthNet completed the training of one physician and two nurses nominated from each of seven hospitals and supplied them with the basic equipment and materials. The training for staff from the remaining four district hospitals was underway by the end of the year. On a national level, there is still a real need for specialist orthopaedic care. HealthNet continued to support the King Faisal Hospital and the Gatagara centre for disabled children by providing an orthopaedic surgeon, equipment and materials. By a convention signed in mid-1997 with the University Hospital of Butare, it was agreed that this surgeon should work alongside a national counterpart in both centres to ensure that they develop increased technical skills.

Social rehabilitation of disabled people is just as important as the physical side and HealthNet therefore both initiates and supports moves to develop an integrated national plan. Technical and financial support is given to the General Association of the Disabled in Rwanda, an key representative organisation, and works with relevant ministries to develop policies to improve the active participation of disabled people in society.

Both the training and support activities will continue in 1998 and these will be integrated into the national health system. Further plans include strengthening the referral and counter-referral system between health centres, district and national referral hospitals, introduce training in the prevention of disabilities at health centre level and support the Ministry of Health to develop a system to improve the monitoring of the quality of care.



Southern Sudan

Taking the lead in River Blindness

'River Blindness' was first documented in Africa over a hundred years ago, its name based on the observation that many of those living by the river were blind. In 1926, the life cycle of *Onchocerca volvulus*, the parasitic causative agent, was detailed. For the next 50 years, *O. volvulus* continued to spread throughout sub-Saharan Africa, blinding, maiming and crippling its victims. In 1987, the drug ivermectin, which had been used for animals, was licensed for use in humans. However, the chronic political disruption and instability in Sudan meant that the estimated 800,000 southern Sudanese at risk had no access to the drug until 1995 and even then on a very small scale. A year later, HealthNet became the co-ordinating agency for all the work undertaken by NGOs in fighting this major health threat in southern Sudan.

Location

Bahr el Ghazal, Lakes, Eastern and Western Equatoria,
Jonglei, Upper Nile

Start date

March 1996

Target population

800,000 residents, internally displaced, returnees

Partners

19 international and local NGOs,
Southern Sudan Relief and Rehabilitation Association
WHO African Programme for Onchocerciasis Control

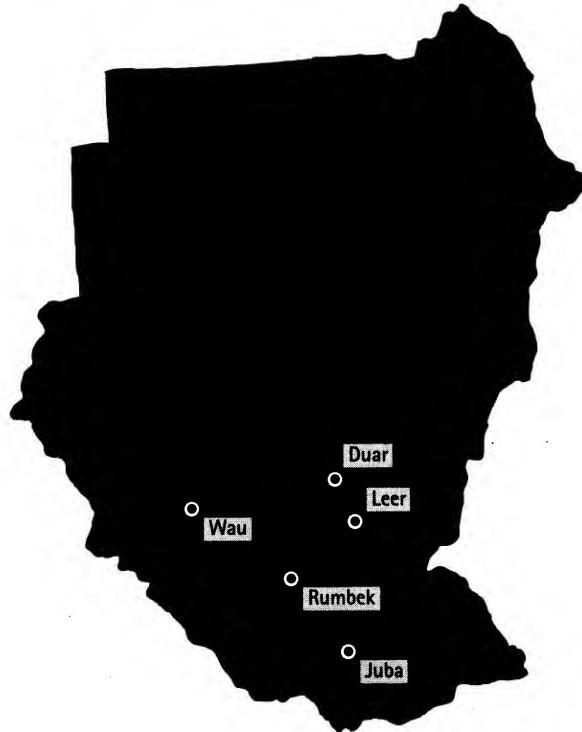
Financed by

VISIO and APOC (WHO)

Expenditure 1997

Fl. 370,941

SOUTHERN SUDAN



control

Years of chronic civil wars since Sudan's independence from Great Britain in 1956 have left the population of southern Sudan suffering the adverse effects of isolation, under-development, insecurity and poverty. The present war between the mainly Christian South and the Islamic fundamentalist North intensified in 1983 and in 1989 the Islamic government cut off services to the South. Much of the population suffers from the effects of malnutrition, lack of adequate health care and major endemic diseases such as malaria, sleeping sickness and dracunculiasis. With the widespread prevalence and severity of 'river blindness', the World Health Organisation pledged additional support to the work of NGOs and a National Onchocerciasis Control Programme was adopted in 1997. This is the second of only two disease control efforts in which the North and the South are working together.

Southern Sudan Onchocerciasis Control Programme (SSOCP)

Ivermectin (Mectizan) is donated by its manufacturer, Merck, to any country with endemic onchocerciasis for as long as necessary. The properties of the drug are such that one oral dose is required once a year for ten years. Applications to begin a treatment programme are filed with the Mectizan Donation Programme in the United States. Due to the number of NGOs working in this field in southern Sudan and the strict reporting requirements of the Donation Programme, HealthNet *is the co-ordinating agency, filing a single application and

responsible for reporting all use of the drug. With so many NGO partners and the fact that many new staff are unfamiliar with onchocerciasis, the real challenge to HealthNet is to ensure excellent communication and training.

Experience in West African onchocerciasis control programmes has shown that the best method of control is community directed treatment with ivermectin, an effort which entails mass distribution of Mectizan to entire communities. It is a strategy which has been adopted and supported by the African Programme for Onchocerciasis Control (APOC) and HealthNet is committed to the concept of working towards community ownership of efforts to control the disease. For it to be successful, committed health workers and community members need to be trained to work with local health systems to reach as many people as possible once a year.

In 1998, HealthNet will work alongside the APOC to build strong partnerships with international NGOs and the communities with the shared goal of establishing a sustainable programme at the end of five years.



Southern Sudan

Primary Health Care Development

The largest country in Africa, Sudan covers some 2.5 million square kilometres with an estimated population of 28 million. Since independence in 1957, the political climate has been characterised by civil war caused in part by a complex interplay of history and culture and in part by economic factors such as the vast oil resources in the south. In 1991, the main liberation army, the SPLA, split into several groups, the most prominent of which were the South Sudan Independence Movement and the SPLA-mainstream. Divisions between these southern groups have served not only to aggravate the conflict but also to create a history of factionalism which is currently undermining the progress towards a peace agreement.

Location

Western Upper Nile region

Start date

March 1995

Target population

120,000 population (local and internally displaced)

Partners

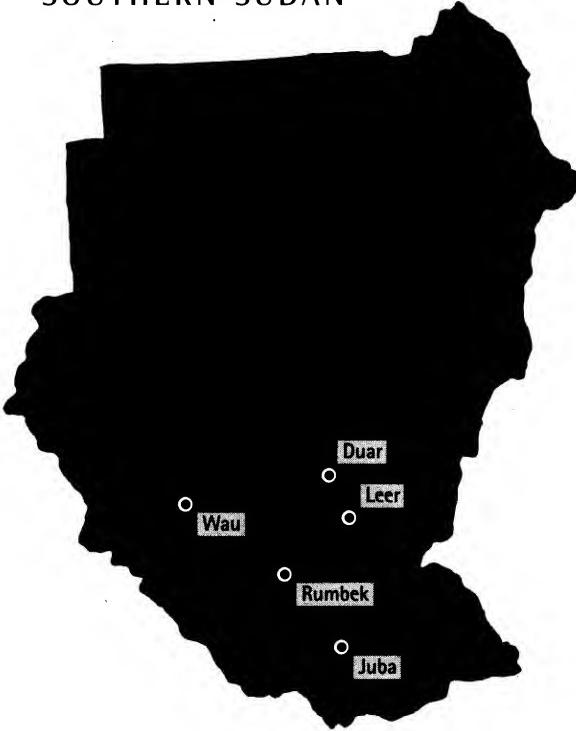
Health Authorities
Local communities

Financed by

MSF Holland
Dutch Ministry of Foreign Affairs

Expenditure 1997

Fl. 616,015

SOUTHERN SUDAN

in Chronic Emergency

All sides of the conflict have used widespread violence and civilian harassment as a tactic or war. Thousands of displaced people live in shanty towns; others have simply died from starvation and disease. Health infrastructures have been partially destroyed and personnel either displaced or recruited into one of the fighting groups. At the same time, the health needs increased dramatically with massive population displacements and severe drought resulting in an upsurge of communicable and water-borne diseases as well as malnutrition. In 1994, the health authorities of both the SSIM and the SPLA officially adopted a Primary Health Care policy with the key principles being to promote a balanced range of curative and preventive health interventions and encourage community involvement. To date, however, international agencies still provide most of the health care with the health authorities themselves, facing continued instability, inter-faction differences and a lack of human and financial resources, taking a reactive rather than proactive stance.

Primary Health Care Development

HealthNet has been supporting the Primary Health Care approach promoted by the health authorities, focusing on Primary Health Care units at peripheral level staffed by community-based health workers. While these units are intended to be supported at district and regional level, extremely poor roads and limited transport are major obstacles which seriously hinder any referral system.

In these conditions of chronic war, HealthNet aims to develop a balance between the provision of care and the development of the health system. Management of the peripheral health units, training and community ownership are the primary focus of the programme.

Currently, HealthNet is actively working with Primary Health Care units in three districts ensuring the provision of appropriate, integrated health services, potable water supplies for the Duar Primary Health Care Centre and training for health staff, communities and authorities. Equally important, HealthNet is working with the communities to enable them to participate in health service provision and promoting health planning and management at regional level.

In Adok and Jagai districts, HealthNet is supporting nine units, particularly with the provision of up-to-date training for the community health workers, 36 of whom graduated from a nine-month course in November. Courses were also provided for the trainers themselves and the community health worker supervisors.

Developing community participation is vital to the programme and is currently primarily focused on the provision of water resources. The priority is to provide each unit and its surrounding area with access to water. With the building of wells being the most reliable means of establishing a water supply to villages, a total of 22 wells have been built and water-related health education and maintenance sessions provided.



The highs and lows of

Irene Goepp

"Recently, I went to Billing where 200 blind and visually impaired people had come in the hope of getting cataract surgery. Some had walked over 100 miles. They were camped out on the hospital grounds with their families and meagre possessions. One afternoon the hospital doctor called a group of 25 people, some in their 20s and 30s, together under a tree to tell them that nothing could be done for them - their blindness was due to onchocerciasis. It was hard to tell what they were feeling as they sat in silence after receiving what was in effect a sentence to spend the rest of their lives in darkness. Their only crime was to be victims of war and poverty. I felt myself screaming inside that this does not have to happen any more - it must not go on."

Irene Goepp, SSOCP Programme Manager, had wide experience of working with 'river blindness' as a field co-ordinator with the International Medical Corps before she joined HealthNet:

"There are difficulties and successes in this field. The main problem here is the unpredictability of the war which forces the evacuation of staff, the movement of the population, disrupts programme activities and means we don't get a consistent coverage with the treatment. At the same time, the sheer length of this conflict means that the pool of literate health workers and volunteers is shrinking and, equally problematic, the past experiences of the communities with toxic drugs used to treat onchocerciasis means that many are dubious about its safety."



working in conflict

Despite all of these, though, there are many aspects of the programme which are running well. The NGO partners want to strengthen and expand their activities and there are well trained, motivated Sudanese health workers capable of training local volunteers to be community-based distributors of ivermectin.

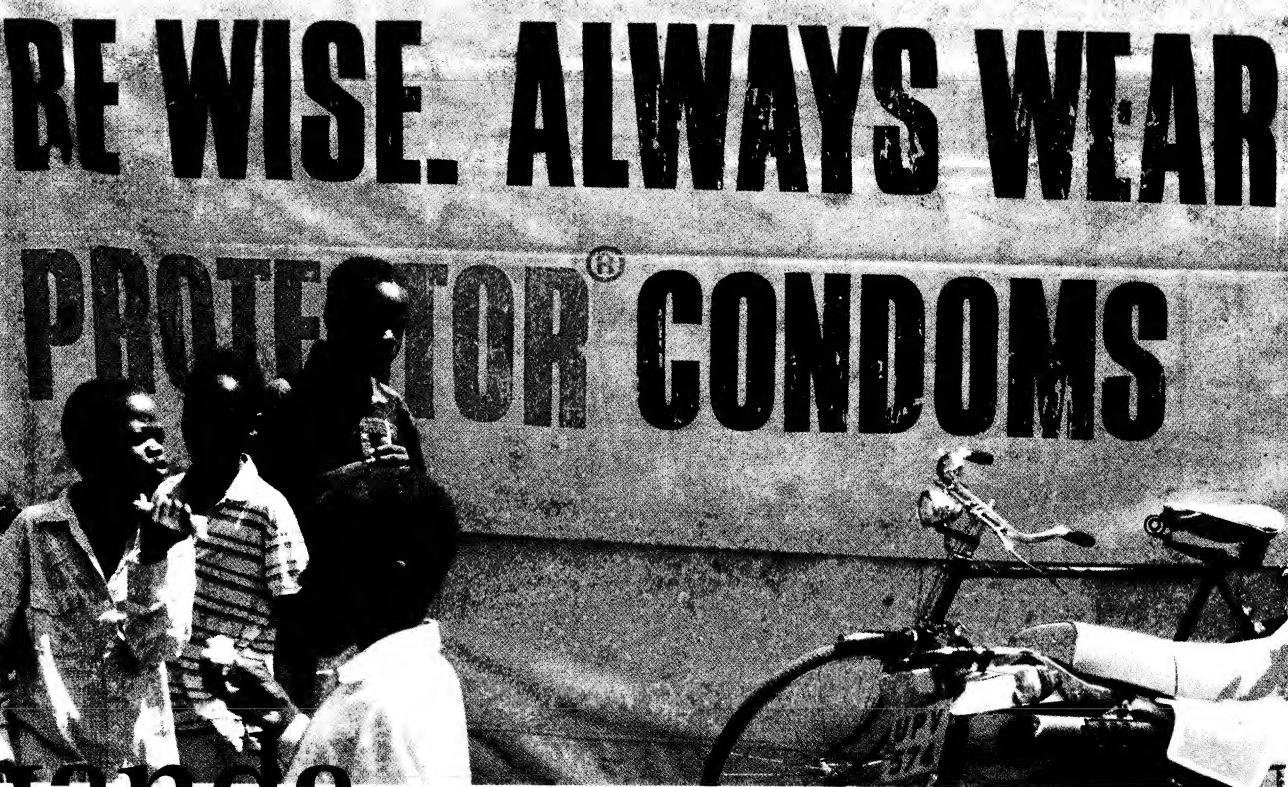
The most exciting recent development was the pledge of support from the WHO's African Programme for Onchocerciasis Control. This new partnership shares the goal of helping south Sudan to achieve a sustainable community-directed approach to oncho control.

Briefing new staff of the NGO partners, many of whom have little experience with onchocerciasis, is a key role for HealthNet. Good communication is essential if the programme is to be well co-ordinated and a great deal of time and effort is spent informing everybody of programme changes. At the same time, everyone involved knows their own areas well and offer good suggestions on how HealthNet can improve aspects of the programme.

1998 began with a major military offensive in Bahr el Gazal, the region most affected by onchocerciasis. 100,000 people fled the fighting and more of the programmes have been disrupted. It makes me think of the slogan from the Vietnam era: "War is bad for children and other living things." When will we ever learn.

On a personal level, I have gained so much from this work. I now have a good practical knowledge of the disease, its treatment and control. I have learned how to be a good teacher by listening to the followers. I have learned to appreciate a country and its inspiring people.

I have many hopes for the future. I hope that the people of Southern Sudan will accept ownership of the community-directed treatment; I hope the NGOs will continue their tireless efforts to bring health care and knowledge to Sudan; I hope for peace."



Uganda

From HealthNet International to

The northern districts of Uganda are the last to share in the overall improvements in the country over the past 10 years.

While relative peace continues in most of the country, there are outbreaks of social unrest and rebel activity. Soroti district, in the North-East, was subject to anti-government rebel violence until 1993 resulting in overall impoverishment, mass displacement and social disruption. Today the district is slowly recovering and the government, with the help of NGOs, has initiated several development activities aimed at boosting economic growth and improving the availability and accessibility of basic services such as health care and education.

Location
Soroti district, Northern Uganda

Start date
June 1994
End date
December 1997

Target population
Risk groups, AIDS patients and their families

Partners
Ministry of Health
Local and international NGOs and community-based organisations
Financed by
MSF Holland
ICCO
World Bank

Expenditure 1997
Fl. 405,511

UGANDA



HealthNeed Uganda

Despite the marked growth in Uganda's economy, the average life expectancy in Uganda has fallen in the past few years from 43 to 40 primarily due to AIDS which is now the main cause of adult death. Officially, 10% of the population, or two million people, is HIV-infected although poor health services and testing facilities mean that in reality this figure probably is much higher. Even the authorities admit that up to a quarter or a third of the population is infected. As a result, virtually every family has lost a close relative and friends. There is an increasing burden of medical expenses, strong or educated workers are dying in their 20s or 30s and absenteeism from work to attend the sick is common. HIV/AIDS awareness campaigns have been carried out throughout Uganda but, with the prolonged instability in the northern districts, these areas have lagged behind.

Soroti AIDS Programme

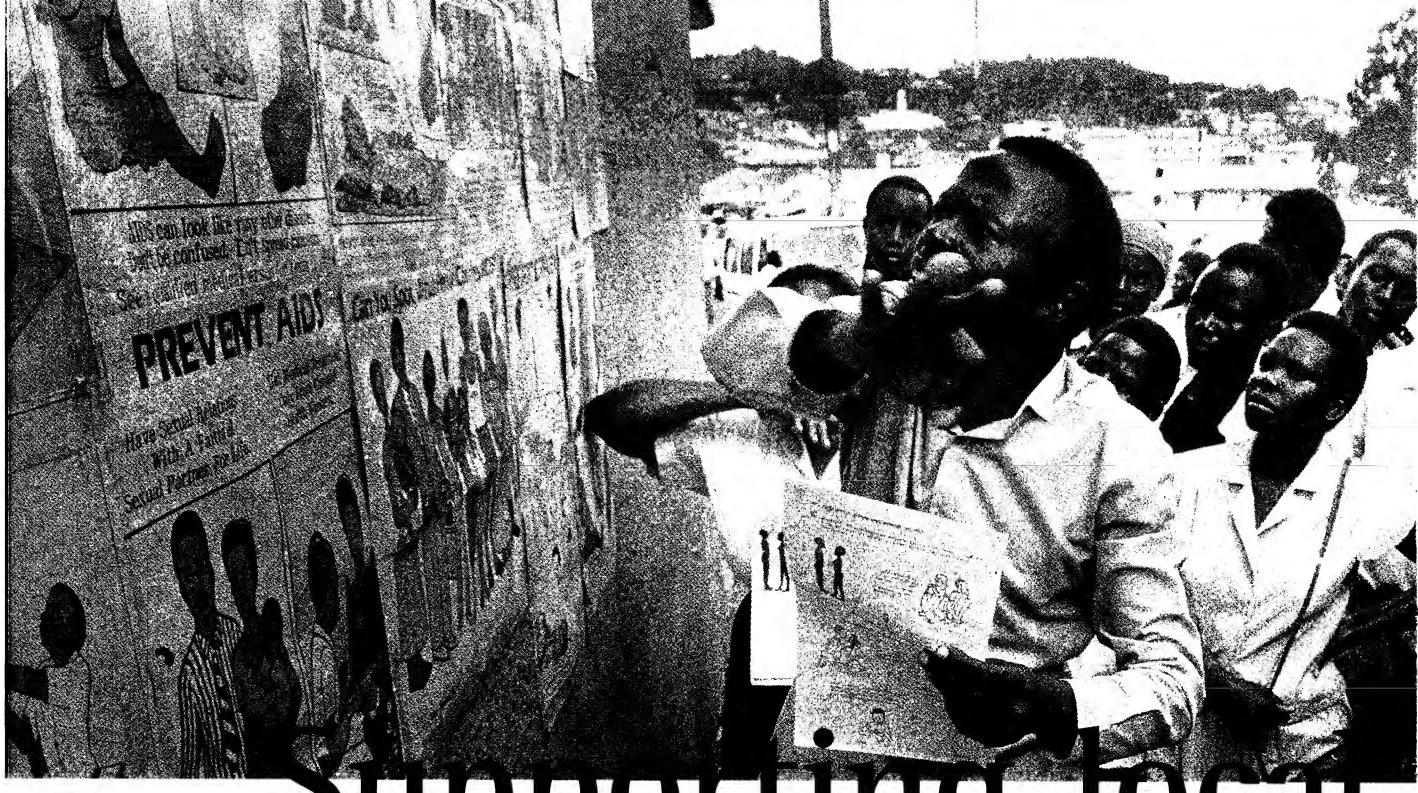
Between June 1994 and November 1997, HealthNet ran an intensive awareness campaign to inform and educate the public in general and specific 'at risk' groups such as fishermen, young people and sex workers in particular.

Working within the policy framework of the Ministry of Health and the National AIDS Control Programme, HealthNet supported the district health services in their efforts to reduce the spread of HIV/AIDS and other sexually-transmitted diseases. Particular emphasis was put on the use of condoms,

which were distributed through a district-wide marketing system.

170 Community Health Educators were trained not only to inform people in their home areas about safe sex but also to provide care and counselling to patients and families living with HIV/AIDS. Other initiatives from the district health authorities, NGOs and community-based organisations were given technical and managerial back-up. Workshops were organised and district AIDS co-ordination committees established.

Towards the end of 1997, in consultation with ICCO, a strategy was developed to transform the HealthNet team into a local NGO under a local governance and with local project management. In November, HealthNeed Uganda was established and the programme responsibilities successfully handed over. With HealthNet acting in an advisory role as member of the Management Board, HealthNeed will implement a new three-year AIDS prevention and control programme financed by ICCO which builds on the success achieved to date.



Supporting local

Richard Ochen

For the past five years, 28 year-old Richard Ochen, a Bachelor of Science, has lived and worked in Soroti District Uganda.

Today he works for HealthNeed Uganda:

"I first worked as a researcher for HealthNet, looking at the situation for people with HIV/AIDS in the communities and to what extent involving health workers, private clinics and traditional healers would help the project. The research opened my eyes to the strengths and weaknesses of health promotion in the district and helped me to really understand the problem of AIDS and its social consequences.

From then, it was a question of how to implement the findings. I think the programme has a very clear direction and is appreciated by the communities and their leadership. There are 170 community-based health educators who are trained to work on the ground. There is no doubt that the situation has changed dramatically. Communities now discuss sex and sexuality and are trying to cope with AIDS at a family level.

After I finished the research, I joined Redd Barna, an international child-centred development organisation, as child advocacy project officer. I stayed there for three and half years, during which I was trained in participatory approaches to development work, project planning, negotiation skills and conflict resolution. It was a real opportunity for me to understand the dynamics and social psychology of working in communities.

I learned how to negotiate for change, to understand inter-communal differences and to appreciate that their indigenous technical knowledge is a key element in working with the communities. These are the concepts which I hope will be useful in my current work with HealthNeed Uganda.



Institutions

HealthNeed Uganda's aim is to develop an organisation based on strong principles and policies which builds on the rich experience gained to date. We are lucky to have inherited highly skilled staff from the HealthNet programme who are inspired by the fact that the programme will not only be maintained but developed even further.

The staff are our strength, as is the fact that there is secured funding for the next three years. Yet the availability of longer-term funding, without which we cannot expand the programme, remains a concern.

Our challenge now is to retain the existing staff and HealthNet's good reputation and create a conducive environment to attract more external funds and resources. I hope the communities will continue to support interventions to control HIV/AIDS. At the same time, it is crucial that we do not concentrate purely on prevention without looking at the long-term implications, for example on the children."

Staff and Relations

Board of Administrators

Chairman	P.K.H. Meyer Swantée
Secretary	J. de Milliano
Treasurer	H.J. Meijman
Member	A.M.F. Winkler B. van der Kolff-KarsSEN

Amsterdam Staff

Director	Egbert Sondorp <i>(until February 1998)</i>
Director's Assistant	Marie-José Pruyn
Senior Programme Manager	Jackie Lemlin Vincent Faber <i>(from June)</i>
Desk Co-ordinator	Judith Zaal Annelies Gieles
Financial Manager	Jeroen Mous
Management Accountant	Liliana Jauregui Bordones
Bookkeeping/Administration	Els van Lindt Pieter Woldendorp <i>(from April)</i>
Rumenia Project	Gaby Oltean-Lungu

International Field Staff

Afghanistan/Pakistan	Marleen Deerenberg Linus Harms Marijke Koggel Ahmed abd el Rahman Sonia Bertrand Sean Hewitt Mark Rowland Hugh Reyburn Alexandra Simon-Taha	Ethiopia	Peter Driedijk Arlette Meuwis
Angola	Patrick de Milt	Georgia	Susan Landfield Eric Schouten
Bosnia	Bart Smet	Haiti	Christine Bousquet
Cambodia	Jasmine Angehrn Mary Dunbar Debra Hartley Joost Hoekstra Pratap Jayavanth Nagi Shafik Maarten Thomas Froukje Zwaga	Kenya / South Sudan	Irene Goepf Bob Matemera Marc Vandenberghe Dirk Calcoen
Djibouti	Joseph Ntaganira	Mozambique	Linda Casey Carolien Albers Marcia Alves de Souza Jutta Heering Geert Leerink
		Peru	Naimeh Baidoun Patricia Hammer
		Rwanda	Willeke Kempkes
		Uganda	Pieter Paul Gunneweg Patricia Schwerzel

External Consultants

Advisory, training program South Sudan	Elgin Hackenbruch
Project formulation, Ethiopia	Jeanet van de Korput
Project assessment and formulation, Bosnia	Geertruid Kortmann
Essential drugs program, Georgia	Chiel Lijdsman
Project formulation, Mozambique	Angela Brown

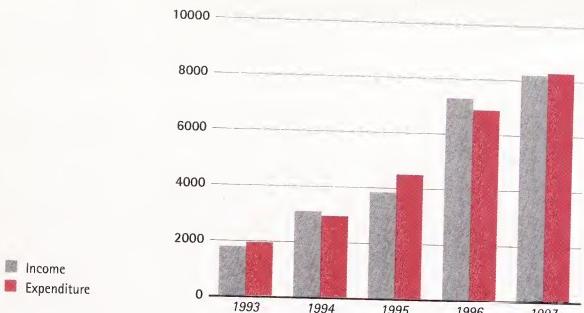
Bankers

ABN AMRO Bank NV
Leidseplein 25
Amsterdam

Auditors

KPMG Klynveld Accountants NV
Burg.Rijnderslaan 10-20
Amstelveen

Stichting HealthNet International, Amsterdam
Financial statements
1997

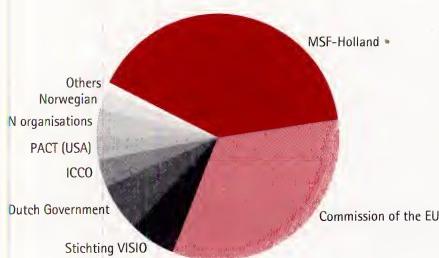


Foreword

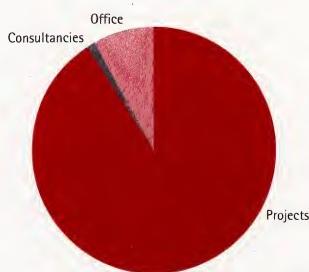
to the Annual Financial

As has already been mentioned in the Director's report, in terms of overall income and expenditure HealthNet has continued to grow, as is illustrated above. However, for the first time since 1993, the organisation incurred a deficit of Fl. 191,274. The project expenses in 1997 were financed from designated and restricted funds in the amount of Fl. 375,085. Therefore we could still appropriate a positive balance of Fl. 165,811 to our unrestricted funds, thus bringing our accumulated unrestricted funds to Fl. 299,378. This is still a very modest amount in relation to our total turnover but, considering the fact that we are not active in private fund-raising, this balance provides us with a reasonable reserve for unexpected negative financial developments. The project support fund, meant to complement insufficient grants from institutional donors, cover costs of exploratory or assessment missions and bridge funding gaps, has been depleted and a request for an additional grant from MSF-Holland to this fund will be made in 1998.

I received Project Grants in 1997



Expenditures in 1997



Statements

Project grants remain by far our biggest source of income and in 1997 these grants made up 96% of our total income. The turnover related to consultancy work for third parties has dropped considerably due to the decrease of such work. Other income sources have been unsolicited donations, interest and income from cost recovery schemes.

Looking at the funding sources we see that our principal donors, MSF-Holland and the European Union, have a share of respectively 44% and 35% in the project grants which have been received in 1997. At some distance follow other donors such as the private foundation VISIO and the Dutch Government, with shares of 7% and 5% respectively.

On the expenditure side the following facts emerge: our net indirect cost rate, which is the ratio of Office Expenses versus Project and Consultancy Expenses, turned out to be 10.6% in 1997 in comparison to 9.7% in 1996. However, the gross rate has decreased, the rate for 1997 is 12.7% compared to 14.1% in 1996. The difference between the two ratios is the personnel costs of Amsterdam-based programme staff, which are directly attributable to projects and consultancies, an amount of fl. 140,600 in 1997 (1996: fl. 235,598). For calculation of the net rate this amount is included in Project and Consultancy Expenses and for the gross rate it is included in the Office costs.

The Project Expenses have also increased. Although at the end of 1997 the number of activities was not larger than at the end of 1996, the average number during the year was somewhat higher as was the average volume of a project. On the contrary, the volume of consultancies and related expenses have decreased since 1995, the reasons for which have already been mentioned in the Director's report.

Balance Sheet at 31 December 1997
(After Appropriation of the Balance of Income and Expenditure)

(in Dutch guilders)

	Note	1997	1996
Assets			
Fixed Assets	3	88,242	79,728
Receivables From Supporting Institutions	4	6,932,880	6,912,127
Other Receivables		140,409	159,299
Cash and Banks	5	2,502,089	2,643,795
		<u>9,663,620</u>	<u>9,794,949</u>

Liabilities

Loan MSF-Holland	6	360,000	405,000
Budgetary Commitments	7	8,440,273	8,419,446
Current Liabilities	8	226,426	142,308
		<u>9,026,699</u>	<u>8,966,754</u>
Total Assets Less Liabilities		<u>636,921</u>	<u>828,195</u>

Representing:

Funds	9		
Unrestricted funds		299,378	142,080
Designated funds		303,692	438,764
Restricted funds		33,851	247,351
		<u>636,921</u>	<u>828,195</u>

Statement of Income and Expenditure

for the year ended 31 December 1997

(In Dutch guilders)

	Note	1997	1996
Income			
Project Grants		7,912,001	6,477,654
Consultancies	10	55,897	150,240
Donations		77,148	317,295
Interest		49,096	48,732
Other	11	150,439	353,208
		8,244,581	7,347,129
Expenses			
Projects	12	7,548,024	6,034,526
Consultancies	10	76,404	181,485
Office	13	811,427	604,755
		8,435,855	6,820,766
Balance of Income and Expenditure		-191,274	526,363
Appropriation of the Deficit/Surplus 9			
Unrestricted funds		165,811	294,063
Designated funds		-143,585	114,086
Restricted funds		-213,500	118,214
		-191,274	526,363

Notes to the Financial Statements

General

The foundation STICHTING HEALTHNET INTERNATIONAL was incorporated on October 26, 1992. The main objective of the foundation is to contribute to a sustained improvement of the health of vulnerable population groups in areas hit by crises by means of a development oriented approach, as soon as this becomes possible.

Comparative figures

Where necessary, the figures of 1996 have been reclassified to permit comparability with 1997 in respect of fund balances. The reclassification concerned Fl. 210,000 from designated to restricted funds and Fl. 359,036 from restricted to designated funds.

Accounting policies

The following accounting policies have been applied consistently in dealing with items which are considered material in relation to the financial statements.

Foreign currencies

Transactions in foreign currencies are recorded using the rate of exchange at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies are translated using the rate of exchange at the balance sheet date and gains or losses on transactions are included in the profit and loss account.

Fixed assets and depreciation

Tangible fixed assets are stated at the historical costs less depreciation. Depreciation is provided at the following rates:

Office furniture	14.3% per annum
Office equipment	20.0% per annum
Office reconstruction	33.3% per annum
Computer hardware and software	33.3% per annum

Other assets and liabilities

All other assets and liabilities are stated at nominal value

Income and expenditure

Income and expenditure are recorded in the period to which they relate.

Project grants

Pledged project grants and the resulting budgetary commitments are stated in the balance sheet on the date of the pledge. Grants are recognised as income in the statement of income and expenditure in proportion to the progress of the project.

Costs

The expenses of the Amsterdam office staff directly attributable to projects, are stated as such under the corresponding heading.

3 Fixed Assets (In Dutch guilders)

	Furniture	Reconstruction	Equipment	Computers	Total
Cost					
Balance at 1 January 1997	44,960	-	23,385	70,299	138,644
Additions	12,191	19,948	3,094	13,178	48,411
Disposals	-	-	-2,632	-2,491	-5,123
Balance at 31 December 1997	57,151	19,948	23,847	80,986	181,932
Depreciation					
Balance at 1 January 1997	7,265	-	17,479	34,172	58,916
Charge for year	8,161	4,987	4,719	20,497	38,364
Disposals	-	-	-2,413	-1,177	-3,590
Balance at 31 December 1997	15,426	4,987	19,785	53,492	93,690
Net book value					
At 31 December 1997	41,725	14,961	4,062	27,494	88,242

4 Receivables From Supporting Institutions (In Dutch guilders)

	1997	1996
Balance at 1 January	6,912,127	6,132,063
Add: Pledged project grants	8,286,147	7,038,594
Less: Received project grants	-7,908,984	-6,057,642
Non-applied project grants	-427,719	-297,683
Exchange differences	71,309	96,795
Balance at 31 December	6,932,880	6,912,127

Notes to the Financial Statements

Receivables From Supporting Institutions (continued) (In Dutch guilders)

Project grants have been received from:

	1997	1996
Commission of the European Union	2,806,594	2,179,240
Dutch Government (DGIS)	433,917	313,917
ICCO	180,928	-
Norwegian Church Aid	107,761	60,240
MSF-Holland	3,448,036	3,093,010
PACT (USA)	167,737	307,796
Stichting VISIO	529,549	-
United Nations organisations	159,249	-
Others	75,213	103,439
	<hr/>	<hr/>
	7,908,984	6,057,642

Cash and Banks (In Dutch guilders)

	1997	1996
Cash and banks Amsterdam	1,731,025	1,987,924
Cash and banks in project countries	771,064	655,871
	<hr/>	<hr/>
	2,502,089	2,643,795

Loan MSF-Holland

In the first three years HealthNet has been supported financially by MSF-Holland in the form of a subordinated loan of Fl. 450,000. The loan is free of interest with a repayment schedule which has started in 1996 at Fl. 45,000 per year over a period of ten years.

7 Budgetary Commitments (In Dutch guilders)

	1997	1996
Balance at 1 January	8,419,446	8,078,940
Add: Pledged project grants	8,286,147	7,038,594
Less: Applied project grants	(-7,912,001)	-6,477,654
Non-applied project grants	(-427,719)	-297,683
Exchange differences	74,400	77,249
Balance at 31 December	<u>8,440,273</u>	<u>8,419,446</u>

Overview of budgetary commitments per country:

Afghanistan	4,108,811	2,113,346
Angola	146,815	-
Cambodia	502,915	714,093
Djibouti	-	268,872
Ethiopia	316,517	598,528
Georgia	515,697	956,942
Haiti	157,242	346,906
Mozambique	-	528,442
Nicaragua	-	-
Pakistan	12,246	475,604
Peru	1,281,820	-
Romania	358,585	559,671
Rwanda	796,919	283,066
south Sudan	238,164	1,338,407
Uganda	4,542	235,569
	<u>8,440,273</u>	<u>8,419,446</u>

8 Current liabilities (In Dutch guilders)

	1997	1996
Creditors	38,328	54,045
MSF-Holland	21,660	1,777
Other	166,438	86,486
	<u>226,426</u>	<u>142,308</u>

Notes to the Financial Statements

9 Funds (In Dutch guilders)

	Unrestricted	Designated	Restricted	Total
Balance at 1 January 1997	142,080	438,764	247,351	828,195
Appropriation of the deficit/surplus	165,811	-143,585	-213,500	-191,274
Add/(less): Inter fund transfers	-8,513	8,513	-	-
Balance at 31 December 1997	<u>299,378</u>	<u>303,692</u>	<u>33,851</u>	<u>636,921</u>

Unrestricted funds

The unrestricted funds consist of accumulated funds which may be used for purposes as approved by the directors.

Designated funds

The designated funds consist of the *fixed assets capital fund*, representing the net book value of the fixed assets of the foundation, and cost recovery funds related to the malaria control program in Pakistan and Afghanistan. This fund is increased by the income from sold mosquito nets and decreased by expenditures related to the replenishment of supplies. Although the sales price is below cost price, the surplus is caused by a free supply of nets by UNHCR and the European Commission (see also note 11).

Restricted funds

The restricted funds consist mainly of the *project support fund*, set up and sponsored by MSF-Holland for exploratory or assessment missions, bridging funding gaps and to complement insufficient grants from institutional donors.

Other restricted funds are formed by not yet expended restricted donations.

10 Consultancies

In 1997 expenses under this heading mainly include feasibility studies and assessment missions, carried out for the identification of new activities. The expenses include direct salary costs in the amount of Fl. 8,000 (1996: Fl. 89,708) related to staff which are based at the Amsterdam office.

11 Other income

Other income represents the gross revenues from cost recovery schemes of which the largest concerns the sale of mosquito nets in Afghanistan. At the end of the year the net revenues - being gross sales minus project costs - are added to the designated funds.

12 Project expenses (In Dutch guilders)

	1997	1996
Expenses per country:		
Afghanistan	1764,103	530,247
Angola	138,078	-
Cambodia	955,419	707,176
Djibouti	156,027	220,381
Ethiopia	445,979	259,543
Georgia	560,056	9,933
Haiti	168,682	179,675
Mozambique	657,997	571,097
Nicaragua	-	451,894
Pakistan	445,363	1,441,843
Peru	179,543	10,514
Romania	200,127	36,472
Rwanda	484,183	662,488
South Sudan	986,956	623,689
Uganda	405,511	329,574
	<hr/> 7,548,024	<hr/> 6,034,526

Expenses per cost category:

Expatriate staff	2,558,236	2,041,310
National staff	1,770,526	1,321,904
Project administration costs	931,702	614,468
Transportation	737,282	408,465
Training/health education	362,614	352,046
Medical and other supplies	1,187,664	1,296,333
	<hr/> 7,548,024	<hr/> 6,034,526

The expatriate staff expenses include direct salary costs to an amount of Fl. 132,600 (1996: Fl. 145,890) related to staff which have been based at the Amsterdam office.

Notes to the Financial Statements

3 Office expenses (In Dutch guilders)

	1997	1996
Salary and social security costs	535,991	376,173
Pension costs	48,727	34,934
Other personnel costs	23,227	29,521
Office rent and utilities	68,258	67,703
Office supplies & services	90,135	66,347
Audit, advice and other costs	45,089	30,077
	<hr/> 811,427	<hr/> 604,755

4 Personnel

The Amsterdam office employs 8.4 staff in Full Time Equivalents at the end of 1997 (1996: 6.8 FTE's)
The members of the Board are not employed by the foundation and receive no remuneration.

Amsterdam, 20 May 1998

The Board

P.K.H. Meyer Swantée, *Chairman*
J. de Milliano, *Secretary*
H.J. Meijman, *Treasurer*
A.M.F. Winkler
B. van der Kolff-KarsSEN

Auditor's Report

Introduction

We have audited the annual financial statements for the year 1997 of the Stichting HealthNet International, Amsterdam. These annual financial statements are the responsibility of the stichting's board.

Our responsibility is to express an opinion on these annual financial statements based on our audit.

Scope

We conducted our audit in accordance with auditing standards generally accepted in the Netherlands. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the annual financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the annual financial statements. An audit also includes assessing the accounting principles used and significant estimates made by the board, as well as evaluating the overall presentation of the annual financial statements. We believe that our audit provides a reasonable basis for our opinion.

Opinion

In our opinion, the annual financial statements give a true and fair view of the financial position of the stichting as of 31 December 1997 and of the income and expenditure for the year then ended in according with accounting principles generally accepted in the Netherlands.

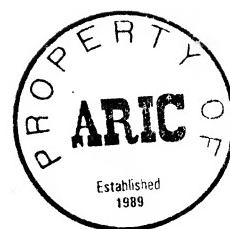
Amsterdam, 20 May 1998

KPMG Accountants N.V.

Colophon

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